PLASTIC SURGERY
OF WESTCHESTER

INTRAVENOUS (IV) INFUSION THERAPY INTAKE FORM

Patient Information:

Name: _____ Date: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone _____: (C) _____ (W) _____

Date of Birth: _____ Age: _____ Sex: M / F

Occupation: _____ Email address: _____

In case of emergency, please contact: Name: _____ Phone: _____

How did you hear about us? □ Internet □ Facebook □ Walk-in □ Friend: _____

Which statements best describe why you are here today? (Please check all that apply)

□ I want to have more energy and feel better overall

□ I want to do everything I can to nourish my body

□ I want to prevent getting sick

□ I want to recover quickly from my surgery or illness

□ I want to slow the aging process

□ I want to feel and look younger

□ I want to have smoother, brighter and more vibrant skin

□ I want to cleanse my body of toxins

□ I want to recover quickly from a hangover

□ Other _____

MEDICAL HISTORY

Are you pregnant or breastfeeding? Yes / No

Have you ever been told that you have an electrolyte imbalance or other abnormal labs?

(Please check and circle all that apply)

□ High or low magnesium levels	□Yes	□No
□ High or low calcium levels	□Yes	□No
□ High or low potassium levels	□Yes	□No
□ High or low sodium level	□Yes	□No
□ Other _____		

If yes to any of the above, a copy of your most recent bloodwork may be required

Are you a diabetic? Yes / No

Are you a smoker? Yes / No If Yes, how much do you smoke? _____

How many alcoholic drinks do you consume in a week?

_____

Do you use any recreational drugs? Yes / No

If Yes, which ones and how often?

_____

Please list everything you are currently taking:

Prescription Medications – Strength – Frequency – Condition being treated

_____

_____

_____

Over the Counter Drugs – Strength – Frequency – Condition being treated

_____

_____

_____

Vitamins and Other Supplements – Strength – Frequency – Condition being treated

_____

_____

_____

Name (First, Last) and DOB: _____

MEDICAL HISTORY CONTINUED

Do you take Digoxin (Lanoxin) for a heart problem? Yes / No

Do you take any diuretics or water pills? Yes / No If Yes, please list: _____

Do you take any steroids, i.e. Prednisone? Yes / No If Yes, please list: _____

Do you have any medication or food allergies? Yes / No

If Yes, please list: _____

Do you have any of the following conditions? (Please check all that apply)

□ Blood pressure problems (High or low)

□ Heart Problems

□ Stroke or "mini-stroke"

□ Kidney Problems

□ Kidney Stones

□ Asthma or COPD

□ Difficult Breathing

□ Sickle Cell Anemia

□ Parathyroid problems

List any other medical conditions you have (not mentioned above):

_____

_____

_____

List of all surgical procedures you've had with approximate dates:

_____

_____

Is there anything else you'd like the nurse and physician to know?

_____

_____

_____

_____

Name and DOB: _____